

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ the undersigned, understand that from time to time

 Print Your Name
 the Health Care Facility _____
 Health Care Facility

May require certain information about assistance I am applying for or receiving from the NH Department of Health and Human Services, Division of Family Assistance (DFA). I hereby authorize DFA to release the following information to the Health Care Facility for the specific purposes outlined below:

Type of Information	Purpose for Requesting this Information
Date of DFA application(s), expected date of eligibility, what my patient liability is and the begin date.	Basic administration of my long-term care/nursing home assistance.
Date my Medicaid case opened and my Medicaid Identification Number(s)	Processing of Medicaid reimbursements for payment to the long-term care facility for my care.
Sharing eligibility information, which can be used to determine eligibility such as income and resources.	Processing the initial and redetermination application for Medicaid assistance.
Reason for the denial of my application such as income or resources, transfers, failed to provide information, ect.	Basic administration of my long-term care/nursing home assistance.

I understand that I have the option to provide any or all of the requested information myself.

I understand that any use of the above information inconsistent with these purposes is forbidden.

I understand that the long-term care facility may not release information provided under this authorization to any other person without my written permission.

 Signature Date

If the signature above is not that of the person to whom the requested information pertains, the relationship of the signer to that person must be indicated, the signature must be witnessed, and verification that the signer has the authority to represent the person in these matters with DFA must be provided upon DFA request.

 Relationship to You Witness Date